

Person-based contextual therapy applied to a complex case of schizophrenia

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Abstract

Background: Psychological therapies are becoming more and more important in schizophrenia, and not as mere adjuncts to medication. The psychotherapy of schizophrenia is taking on a new lease of life in the wake of person-based phenomenological and psychological developments.

Method: The case in question was a complex one, with variegated symptomatology that had persisted over many years. Approaching the case from the perspective of person-based cognitive therapy allowed us to understand the psychotic symptoms in the biographical context and to apply a therapy focused on the patient's recovery of her sense of self and of life. **Results:** At the end of the therapy and throughout the 12-month follow-up, the psychotic experiences had practically disappeared, or ceased to be disturbing, and the patient had become re-integrated in social life.

Conclusions: Psychotic symptoms take on meaning in the biographical context. Adopting this perspective can aid the psychopathological explanation of the disorder and provide significant therapeutic help, more focused on recovery. Psychological therapy has shown itself to be viable in complex cases treated within the public-sector healthcare context.

Keywords: Schizophrenia, psychotic experiences, psychotherapy.

Resumen

Aplicación de la terapia contextual basada en la persona a un caso complejo de esquizofrenia. Antecedentes: las terapias psicológicas están siendo cada vez más importantes en la esquizofrenia, y no como meras adjuntas a la medicación. La psicoterapia de la esquizofrenia está cobrando nueva vida a la luz de desarrollos fenomenológicos y psicológicos centrados en la persona. **Método:** se presenta un caso complejo, de abigarrada sintomatología y larga duración, sin que hasta ahora la medicación produjera cambios clínicos significativos. La formulación del caso de acuerdo con la terapia cognitiva basada en la persona permitió entender los síntomas psicóticos en el contexto biográfico y llevar a cabo una terapia centrada en la recuperación del sentido del yo y de la vida. **Resultados:** al final de la terapia y en el seguimiento de un año las experiencias psicóticas habían desaparecido prácticamente o dejado de ser perturbadoras y la paciente se había reintegrado en la vida social. **Conclusiones:** los síntomas psicóticos cobran sentido en el contexto biográfico. Esto puede servir a la explicación psicopatológica y a una ayuda terapéutica significativa, más centrada en la recuperación que en el mero sostenimiento, que fácilmente termina en "abandono" asistencial y existencial. La terapia psicológica muestra ser viable en casos complejos atendidos en dispositivos públicos.

Palabras clave: esquizofrenia, experiencias psicóticas, psicoterapia.

The resurgence of psychological therapy in the field of schizophrenia can be attributed to two circumstances. On the one hand, a clear dissatisfaction with standard, medication-based care, and on the other, growing evidence of the viability and efficacy of psychological therapy.

Dissatisfaction with medication-based approaches can be found not only in the clinical care context, but also in the field of research. As far as the mental healthcare context is concerned, the Schizophrenia Commission set up in November 2011 by Rethink Mental Illness described standard care for schizophrenia as "shameful", leading it to entitle its report as The Abandoned Illness (The Schizophrenia Commission, 2012). As the report states: "Time after time, we heard the same thing. Fundamentally,

what service users want is to be listened to, to have their experiences validated, to be seen as a person and not just a set of symptoms, and to be given hope. Surely that's not such a big ask?" In its recommendations, the commission stresses the importance of improving access to the psychological therapies. With regard to research, an editorial in Schizophrenia Bulletin acknowledges that in the last 30 years, no new pharmacological formula has been developed, despite the thousands of millions of dollars invested (Figiber, 2012).

The growing evidence of the role of psychological therapy in schizophrenia is acknowledged and endorsed in the NICE (2010) report and in various reviews (e.g., Lemos, Vallina, Fonseca, Paino, & Iglesias, 2012). Psychological therapy can also constitute a first-line treatment, with medication as an adjunct, where necessary, within a perspective based more on the person than on the reduction of symptoms (Pérez-Álvarez & García-Montes, 2012). Cognitive behavioural therapy has played a leading role in this positive reappraisal of the psychological approach. Thus, therapy has evolved from a perspective focusing on the reduction of symptoms through "disputing" the cognitive content, to another revolving

around the person as the context in which to integrate and accept experiences and recover the sense of self (Tai & Turkington, 2009). Thus, Paul Chadwick has developed Person-Based Cognitive Therapy for distressing psychosis (PBCT) (Chadwick, 2006).

PBCT represents an evolution of traditional cognitive therapy for the treatment of delusions, voices and paranoia (Chadwick, Birchwood, & Trower, 1996). This new therapy incorporates several progressive innovations, such as acceptance and validation in the therapeutic relation, Vygotsky's concept of Zone of Proximal Development that sets the style of the patient-therapist collaboration, mindfulness as a therapeutic strategy, the self as a framework for the personalized process, and meta-cognition in the understanding of the disturbance and the articulation of processes of change (Chadwick, 2006). Building on these innovations, PCBT is organized in line with four basic dimensions: (a) the meaning of psychotic experiences in the biographical context, (b) acceptance and mindfulness as an alternative to "fighting" the symptoms, (c) the development of positive schemata about the dynamic nature of the self, and (d) the self as the basis of a perspective that permits a meta-cognitive understanding of the complex, contradictory and changeable nature of oneself.

PBCT enjoys increasing empirical support, obtained in applications both to individual cases (Chadwick, 2006; Newman, Harper, & Taylor, 2009) and groups (Chadwick, Newman, & Abba, 2005; Chadwick, Hughes, Russell, & Dagna, 2009; Dannahy et al., 2011). In both types of intervention, the results obtained indicate clinical improvement characterized by a reduction of delusional ideas and the anxiety and depression related to them, by lower levels of distress and conviction associated with the voices, and by increased confidence in one's ability to live with the voices. A qualitative study based on a semi-structured interview aimed at understanding participants' experiences of person-based cognitive therapy groups for distressing voices lent support to the claimed benefits of re-evaluating beliefs about voices, strengthening positive self-schemata, mindfulness practice and principles, and moving towards a sense of self (May, Strauss, Coyle, & Hayward, 2012).

PBCT coincides with Acceptance and Commitment Therapy (ACT) in its objective of changing the relationship with stressful experiences through acceptance and mindfulness, rather than fighting with the symptoms (Gaudiano & Herbert, 2006). ACT stresses the person's orientation towards action and commitment in the context of values (García-Montes et al., in press; Pérez-Álvarez & García-Montes, 2012; Veiga-Martínez, Pérez-Álvarez, & García-Montes, 2008). PBCT and ACT constitute the most significant innovations of psychological therapy in the field of psychoses. In this article, we shall show the viability and efficacy of this type of approach in a complex case and within a natural clinical context in public-sector mental healthcare.

Method

Participant

The case studied is that of a 41-year-old woman whom we shall call Ana. She is divorced, and lives with her son, who is 21 years old and unemployed. She works as a school cleaner. She was diagnosed with paranoid schizophrenia at age 14. Since then, she has been prescribed various types of medication by different psychiatrists. Her current medication is based on perphenazine

and diazepam. She has never received psychological treatment previously. Her adherence to the medication and motivation to recover are good. The psychological treatment was provided at the Mental Health Centre in Torrelavega, an outpatient facility of the Cantabrian Health Service, which forms part of Spain's National Health Service network.

Ana presented "first-order" psychiatric symptoms. Thus, she was convinced that people knew what she was thinking because they could hear her thoughts; she had delusions of reference, associated in particular with the television and with people's looks and gestures, as well as a delusion of control and influence; she claimed to be continuously watched by cameras all around her, and controlled by means of a microchip that people "on the other side" had implanted in her brain; she sporadically experienced auditory hallucinations in which she claimed to hear the voice of her father (who was dead) making comments about some of her behaviours or thoughts, and that she sometimes had brief conversations with him; she also presented unpleasant olfactory hallucinations and highly aversive cenesthetic hallucinations in which she perceived that her skull became soft and penetrable, so that she could easily be manipulated or controlled. All of these experiences were associated with high levels of distress, interference and worry, which almost continuously absorbed her mental activity, maintaining her in a state of alert and vigilance, both towards the people around her and towards her own psychotic experiences, and isolating her more and more from a normal everyday life. At the time the therapy began, she maintained contact only with her son, with one of her sisters and with her psychiatrist.

Everything seemed to begin for Ana at age 14, when she was brutally raped. On her arrival home after the assault, her mother was annoyed with her; she blamed her for the rape, saying that the way she dressed and related to men were provocative. Her father, to whom she was very close, maintained a cold and distant attitude, saying nothing about the matter. When she woke up the following day, she began hearing voices. Some of them insulted her: "*Filthy whore! Slut!*"; others gave her murderous orders: "*You have to kill them all; don't leave a single one alive*". She left home and went to live in another town with a friend. It was there that she received her first psychiatric treatment, after being diagnosed with paranoid schizophrenia.

When Ana was 17, her father contracted cancer. She returned home to look after him, and he died shortly afterwards. She developed the belief that her past thoughts wishing her father dead were what caused him to get cancer and die: "*I believe that if I wish really hard for something, especially something negative, and I wish for it with all my might, then what I wish for can happen*". Her feelings of guilt became more acute, and she began having new psychotic episodes, now involving cenesthetic hallucinations. "*I started having these feelings. I couldn't touch my head because it was soft. My brain hurt and I was afraid; it was as though it could be penetrated... an awful sensation... I felt like there was a tap in my head. My head was flooded with water and my brain was shrinking*". Later, she had a dream in which her father appeared, accompanied by other dead people: "*One of those who was with my Dad took out my brain and put a chip in it so as to be able to control me at all times and make me do whatever they asked*". As a result of this dream she believed that from "the other side", they had inserted something in her brain in order to control her.

When she was 21 she became pregnant, and her family put pressure on her to have an abortion, but she decided to have the

child. She lost her job, gave up taking her medication and had a new psychotic episode involving multiples voices that threatened to harm her son. She fled to the countryside, set up home in a hut there, and gave birth. Her partner was unfaithful to her, and she left him to go back home and live with her mother and sister. At age 33 she began a new relationship, which ended up being quite traumatic, involving regular sexual and general physical abuse. Further severe psychotic episodes ensued, which included olfactory hallucinations with strong sexual content.

When Ana was 37, her mother died. At age 41, and coinciding with problems at work, she suffered her last psychotic episode prior to beginning the psychological treatment. She describes it as follows: *“At the end of July, I started seeing shadows. They stalked me at school, checking what I was and wasn’t doing. At first, I granted them no importance, but little by little, they started to get me worked up. Things started to smell bad; my bedroom smelled of sex, and I had to go to the sitting room to sleep, but the sitting room smelled of death; I decided to clean the house from top to bottom, so I turned it upside down, I cleaned everything, and when I went to sleep, my Dad appeared. He told me that people only wanted to lock me up; I replied that he was dead, but he said he had special powers that allowed him to talk to me. He had come because he had something very important for me, but I had to be prepared for it. I went out into the street and people were looking at me, following me, saying bad things about me. I went to the shop and I felt transparent, as though they were hearing everything I said, and I became more and more anxious”*.

Instruments

In addition to the clinical interviews, two scales were used for the assessment of positive symptomatology and negative beliefs.

The Psychotic Symptoms Rating Scales (PSYRATS; Haddock, McCarron, Tarrier, & Faragher, 1999). These two scales are designed to assess delusions and hallucinations. The Auditory Hallucinations Scale rates 11 dimensions (frequency, duration, location, etc.) and the Delusions Scale rates 6 dimensions: amount of worry generated by the delusions, duration of such worry, conviction about the delusional ideas, amount of anxiety they generate, intensity of such anxiety, and the degree to which these beliefs disturb the person’s daily life.

The Evaluative Beliefs Scale (EBS; Chadwick, Trower, & Dagnan, 1999). This instrument assesses the person’s negative beliefs about the self and others. The scale measures 18 negative personal appraisals in relation to 6 aspects: uselessness, antipathy/dislike, weakness, evil, failure and inferiority, grouped into three categories: appraisal of myself, of how others see me, and of how I see others.

Procedure

The therapy was carried out over a total of 53 sessions, spanning a period of two years, initially in weekly sessions, which later became fortnightly, and finally monthly. Post-treatment follow-up lasted one year, with appointments every two months at first, and later every three months. Below, we set out how the case was formulated and how the course of treatment was applied in the six phases.

Phase one: Establishing the therapeutic relation (6 sessions). Given the patient’s initially sceptical and distrustful attitude,

together with the presence of active psychotic symptomatology, it was essential for the sessions to be flexible as regards time-tabling, duration, etc.; it was also important to be empathic and to be accepting of her experiences and problems and of her as a person.

Phase two: Assessment and conceptualization of the case (3 sessions). Although this process is continuous, and begins at first contact with the patient, the application of the scales and formulation of the case took place in this phase. Formulation of the case consists of establishing functional biographical relations between life adversities (traumatic experiences), psychotic experiences, negative personal schemata and personal explanatory models (delusional ideas). Ana explained the symptoms she had (e.g., cenesthasias, hallucinations) through delusional ideas of control and influence. Each time she had a psychotic episode, she experienced high levels of dysphoria, which she relieved via avoidance behaviours, hypervigilance, neutralization or elimination. These psychotic experiences and explanations were related both to the traumatic experiences themselves (rape, rejection by the family, father’s death, abuse from her partners) and the negative personal schemata generated by these traumas (I’m bad, people are bad). Such relations constitute dynamic loops between life events, psychotic experiences, cognitive responses and delusions that lock people more and more into a system of avoidance, thus preventing them from becoming more involved in the kind of life that could help them change for the better (Figure 1).

Next, the following therapeutic objectives were agreed upon: (a) going back to work when sufficient clinical improvement has been achieved, (b) looking at the meaning of her symptoms, beginning with the cenesthasias, the olfactory hallucinations and the delusional ideas, (c) tackling her feelings of guilt, evilness and failure, (d) recovery of her sense of self, and (e) maintenance of the improvement and prevention of relapse.

Phase three: Changing the relationship with the psychotic experiences (14 sessions). Basically, the technique applied was mindfulness, aimed at acceptance of the psychotic experiences without feeling worried, excluded, dominated or absorbed by their “tyranny” (Abba, Chadwick, & Stevenson, 2008). The following transcript is from the beginning of one of the early sessions.

Therapist. You tell me that every time you have these feelings in your skull, you feel severe anxiety and try to get rid of them by any means possible. What you’ve done is fine, but it seems it hasn’t helped you very much. Let me suggest another way, and we’ll see if things go better.

Patient. OK. How are we going to do it?

T. Well, it’s a case of you allowing yourself to have the experience and observing it, feeling it, without trying to eliminate it, change it or judge it, or doing anything to free yourself of it. It’s a question of observing the experience passively, without getting caught up in it, [...]. If you do it like this, experiences will begin to lose their intensity, and become bearable. You can learn to understand them as a sensation, a feeling, nothing else – annoying or uncomfortable, yes, but inoffensive and with no power at all over you or your life.

P. I don’t know whether I’ll be able to do that... Every time it comes on, I feel awful, and I can’t control it.

T. We can try it out here. Let’s see... In this office do you have the same feelings? Do you have the sensation of having a tap in your head?

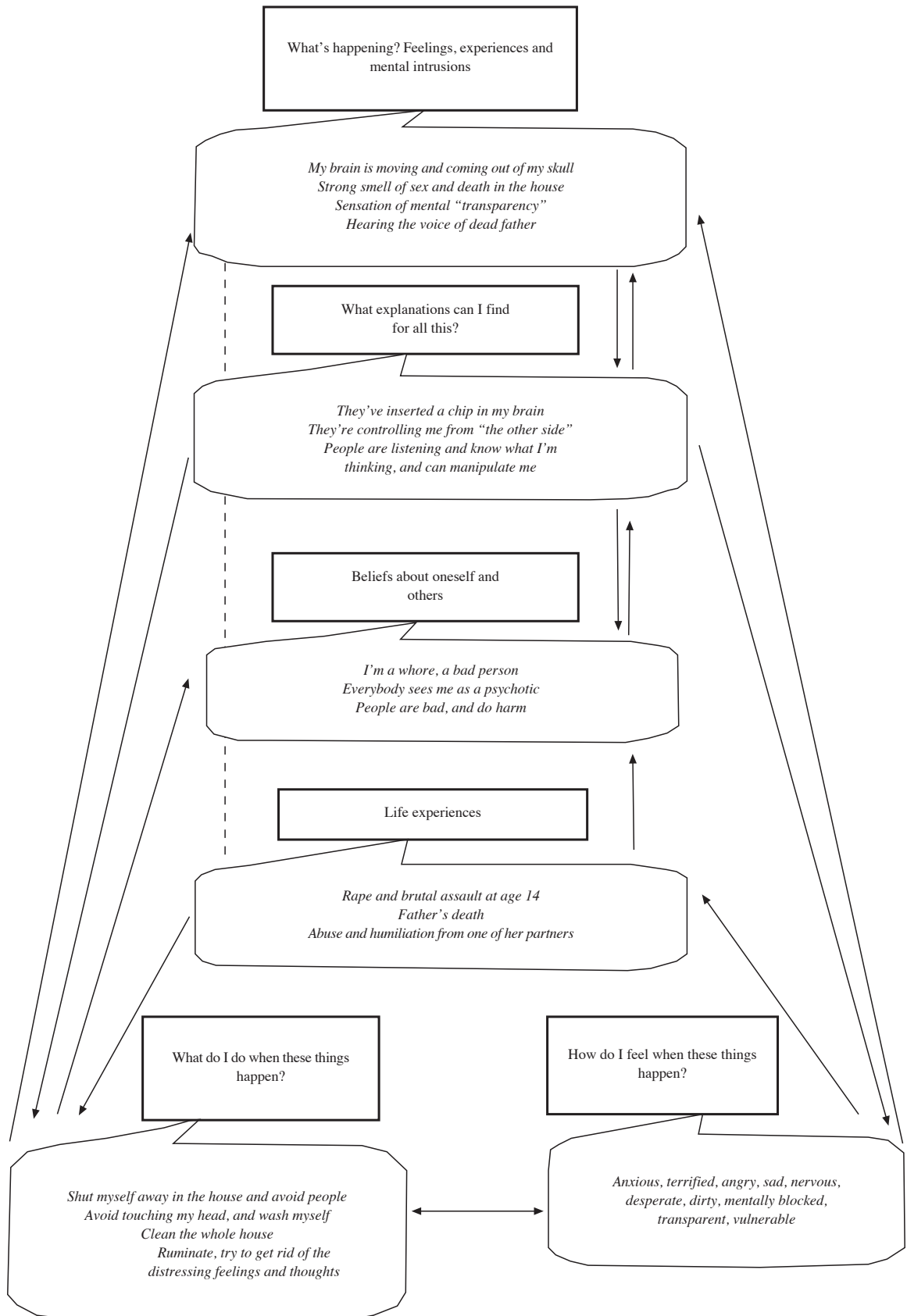


Figure 1. Diagram of case formulation

P. Yes. Sometimes, yes.

T. Well, then, we'll do as follows: we'll both keep quiet for a little while. Close your eyes and concentrate on your feelings; if you start to have those strange feelings, I want you, on the one hand, to tell me out loud what you're experiencing, and on the other, to keep paying attention to those feelings, whatever they are, but without trying to stop them or using any of the tricks you usually use to get rid of them. Tell me clearly, out loud, what you're feeling, that's all you've got to do; tell me what's happening inside you. If at any time you feel you're getting really anxious, use the breathing technique I taught you.

P. OK.

T. Let's begin, then. Get comfortable, concentrate on your sensations, and tell me what you're feeling as you go along.

P. Now I'm feeling as though something was moving inside, like a kind of rocking, and I'm getting very nervous, worked up... it's though my head was getting soft, turning into plasticine. [...] I'm really scared; I can't go on with this! [She opens her eyes and moves nervously in her chair].

T. That's fine. Concentrate on your breathing, on how your lungs inflate and deflate, like bellows, and how the air comes in and goes out of your body.

Ana begins doing breathing exercises with the help of the therapist, and after a short while, becomes calmer. The therapist normalizes these reactions in the context of the patient's conscious contact with the psychotic experiences, without fleeing from them, and encourages her to try again as the session progresses.

Phase four: Addressing the meaning of the symptoms (28 sessions). This phase involves an exploration of the evidence in favour of and against the belief and its utility, as well as the consideration of meta-cognitive interventions related to the link between cognition and emotion. Various techniques are applied, including Socratic dialogue, behavioural experiments, normalization, analysis of evidence, generation of alternative explanations, safety behaviours, and the creation of coherent narratives (Morrison & Barratt, 2010). The exploration and intervention revolve around three delusional ideas: influence and control (*"My brain can be taken out; it can be manipulated, and they've inserted something in it to control me"*), dispersal of one's thoughts (*"People know what I'm thinking; they listen to my thoughts"*) and delusions of reference (*"People around me are constantly talking about me; I can tell from their faces and their gestures"*). These delusional constructions are understood as attempts to explain hallucinatory experiences (cenesthetic, auditory and olfactory) linked, in turn to negative personal appraisals rooted in traumatic biographical experiences. In relation to magical thinking, for example, this is a fragment of the dialogue that took place:

T. OK, you're telling me you have the mental ability to cause pain or even death to whoever you want, just by wishing it?

P. It may seem strange, but yes. Look at what happened to my father.

T. And do the rest of us also have this ability?

P. I suppose so. If I can do it, I suppose other people can, too.

T. But if that were the case, then all we would have to do is wish the worst for anyone who was bothering us, and then

none of us would have any problems. It doesn't seem that problems can disappear just by wishing them away. Nobody would have problems, but we all continue to have problems every day.

P. True...

T. And has this always worked for you? Hasn't there been any time that you've wished a person ill and it's not worked?

P. Well... [thinking] It's true that I also wished Juan (ex-partner) would die... I prayed and everything that he would stop breathing, but nothing happened... I don't know, I must be mistaken or there's something wrong. Maybe it was all a coincidence... a lot of coincidences together can form a mistaken truth. I don't know to what extent it might be a false belief...

After several sessions a reformulation of this aspect was attained, along with the abandonment of this belief: *"I've been thinking about how far thoughts or wishes can have an influence on people, and maybe Oscar's right. Perhaps my thoughts aren't magical, and they don't influence other people at all. It wasn't my hatred that made my father sick; maybe it did him mental harm, but not physical. Maybe it's not true,... maybe I'm just a broken doll playing at being a devil. I think it's time to stop going over and over all this"*.

Phase five: Working with the schemata of the self (16 sessions). The work with schemata focuses on cognitive-affective experiences of the self, both negative – which predominate – (“I’m a bad person and I deserve everything bad that happens to me and more”; “I’m really dumb; I don’t know how to say things”; “It’s my fault that none of my relationships have turned out right”) and positive, to be identified and highlighted. The approach employed was basically that of the “two-chair technique” (Chadwick, 2003, 2006), which allows bringing into play and integrating the two schemata, without the dominance of either one (in this case, importantly, the negative one). Below, we present a transcript of part of the application of this technique to schemata of evilness and failure.

T. Let's see, Ana, you never stop telling me how you're a disaster, a worthless human being who only deserves bad things to happen to her, and that in your life you've never done anything worthwhile. We're going to use the two chairs to analyze this situation. First of all we'll focus for a few minutes on the negative characteristics of your relationships with men. Then you'll change chairs and we'll look at the positive aspects. If you're OK with that, we'll begin with your negative experiences.

P. They were never good. It all started with the rape I told you about, and then it was just one problem after another.

T. What was it that happened, then?

P. I think it was all because of problems with sex.

T. What kinds of problems do you have with sex?

P. It doesn't work. I was always scared stiff of having sex. When I met the father of my son, which was my first relationship, it was a year before we had any sexual contact, and when we eventually tried, I couldn't. Images of what happened [her rape] kept coming into my mind, and I became tense; I would wake up in the middle of the night, shaken up and crying. When we finally did have sex I couldn't reach orgasm, and I faked it.

T. How did you feel then?

P. Dirty, like a sow in a pigsty.

T. What happened in your other relationships?

P. More of the same. With Luis, things started really well, I loved him a lot, but it all turned sour; he wanted sex all the time, in really strange places, and if I protested he insulted me, humiliated me. Several times he forced me [she gives some accounts with lurid details]... I came to feel like a whore.

T. Why did you let him treat you like that?

P. That's what my sister said. At first it was because I was really in love and I didn't want to lose him... who was going to love a psychotic woman? And in the end it was out of fear [...].

T. And what do you think now?

P. That it's all a load of shit [...]; it's not worth it....

T. OK, I can see how much all this affects you [...]. Now we're going to change chairs and leave the negative stuff on that one. On the other one you're going to concentrate on positive experiences and thoughts about your relationships.

P. I don't know whether I'll be able to think of any (half-smiling) [...]. I think the father of my son did love me; he helped me when I went to live in the country, he took me to the hospital to give birth, and he made sure I was admitted so that I could be treated for the psychosis. He still phones sometimes and we talk about our son.

T. It seems they didn't all treat you badly all the time...

P. True. I mean, Juan (a current friend) also says I've got a very nice body, that I look really good for my age. Even if it's a lie, it's nice to hear.

T. And it can't be all lies, Ana. Even though your relationships haven't turned out well, you've had quite a few in all these years, and that means there are things about you that these people have liked. It seems that from here, you can see different things from those you saw from there, from the other chair.

P. Yes, it's nicer being here than being there.

T. Well, as you can see, you're made up of the two of them, but if you look only at the painful things from the first chair, you won't notice the pleasant things you saw from the second one [...].

Dealing with the negative schemata involved working on the rape experience and on her difficulties with sexual relationships, as well as her guilt feelings. This allowed us to understand some characteristic aspects of the case, such as the sensation of a strong smell of sex in certain situations or emotional states, her efforts to please and fit into asymmetrical and unsatisfactory relationships, her low attachment to femininity and her low self-esteem related to body image. In this way, integration of the positive self-schemata and reconstruction of a personal identity based on a self that contextualized the patient's diverse life experiences were attempted.

Phase six: Establishment of new referents and work on relapse prevention (final sessions included in the previous phase). As the psychotic experiences remitted and the self-schemata began to improve, Ana reached a stage – as often occurs in such cases – of stagnation, of fear within her personal development, concerning the “new life” beyond the psychosis. As the patient said: “I’m getting better and better; I’ve got a clear head, and I really feel

pretty well, but I also have a very strange sensation. I feel so good that it seems unreal, like it's an illusion or another delusion...I don't know,... I don't know where it might lead, and that confuses me. It's like renewing yourself little by little. Every day you find some difference, and it feels strange”. In this regard, the interventions suggested by Gumley and Schwannauer (2006) were applied. Thus, the sessions included looking at a “normal mind” and its differences from a “paranoid mind”. An analysis was carried out of the experiences between sessions that Ana noted down in her diary, with the aim of normalizing and endorsing the new experiences. The experiences and events included accepting the joy and satisfaction obtained from certain acts (such as taking biscuits to give to her workmates), appreciating a compliment, feeling satisfied with one's image in the mirror, or accepting praise or affect from others without mistrust or suspicion. This part of the work also included being alert to possible “relapses”.

Results

Ana's clinical state improved as the therapeutic interventions were applied. The improvement was first observed in the reduction of her cenesthetic experiences as the use of mindfulness progressed. After four months, such experiences had practically disappeared; the sensations that persisted were intellectual and affectively painless, and did not disturb her everyday life. Without the feelings about the penetrability of her brain, the theory about brain manipulation and the insertion of the microchip was weakened, and further so by her reappraisal of how magical thinking could have influenced her father's death. Without such guilt, the theory of paternal revenge from “the other side” made no sense. In turn, Ana's rejection of the brain manipulation and control theory meant that her delusions of reference became weakened. Below, we present quantitative and qualitative data in relation to this narrative account of the changes observed.

Quantitative Data. Figures 2, 3 and 4 show the changes in the dimensions of the three delusional beliefs: brain manipulation, control and referentiality, measured by means of the PSYRATS scales at the start of the therapy and after one year of treatment.

The reduction of all the parameters is homogeneous for the three ideas after one year of therapy. There remains some concern over whether these ideas might reappear, but given their lack of active

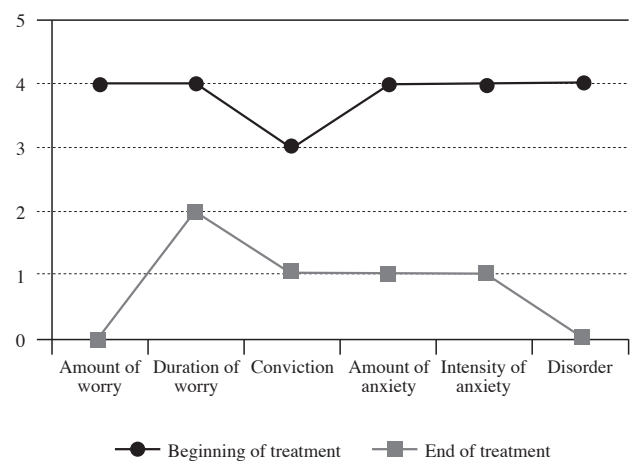


Figure 2. PSYRATS: Evolution of the delusional idea of brain manipulation

presence, the patient's current daily life is not affected. With the reduction of these experiences and delusional ideas, Ana's personal evaluative schemata related to uselessness, failure, inferiority and evilness, detected by the EBS and particularly on the self-self personal appraisals scale, began to change, the score falling from 14 points at the beginning of the therapy to 1 by the end. Likewise,

the self-others rating scale score fell from 5 to 2 points, while the score on the others-self scale fell from 9 to 0 points (maximum score on each scale is 18). These schemata appear to have been deactivated and resituated as just one more mental product pertaining to her diverse psychological ecosystem.

Qualitative data. We present vignettes referring to different aspects of personal recovery, identified in Phase Six and corroborated in the follow-up (Box 1).

The two self-portraits drawn by Ana at the beginning and end of the treatment, respectively, also serve to illustrate the change in her self-image and sense of identity (Figure 5). According to the patient's own explanation, the self-portrait on the left represents her perception of herself at the beginning of the treatment, when everything was confusion, anxiety and chaos, and her "identity" was an amalgam of unconnected or superimposed, distorted experiences, feelings and ideas that came out of her head. The portrait on the right, from the end of the treatment, reflects a readjusted, harmonious image and identity that is pleasant for Ana herself.

At the follow-up, Ana was working normally. She was also beginning a new relationship, and this circumstance, together with her son's decision to join the army and his posting to Afghanistan, brought about a state of stress, but to which, she says, she has reacted well, with no reappearance of psychotic experiences or negative schemata.

Discussion

The case reported was a complex one of psychosis, with a schizophrenia diagnosis, treated successfully with psychological therapy, namely, PBCT. The case in question has some features that make it especially relevant to this field of study. One such feature is that the intervention took place at a mental health centre, in the context of the service provided by a clinical psychologist. It is reasonable to think that without psychological intervention, the case could easily have ended up in a situation of therapeutic, care-related and existential "abandonment".

Another important aspect illustrated in this case is that, from the psychological perspective, psychotic symptoms have meaning. Indeed, this case constitutes a good example of how symptoms of

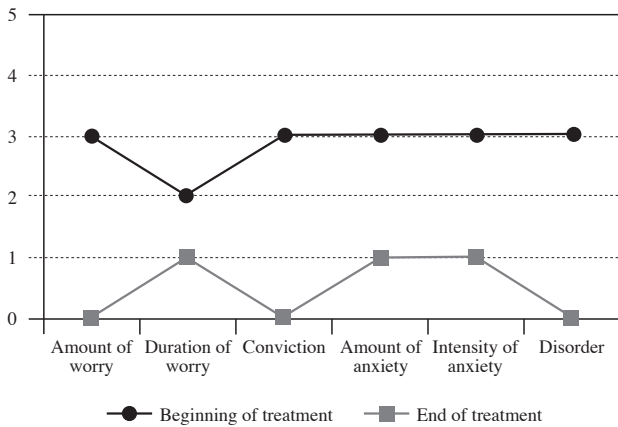


Figure 3. PSYRATS: Evolution of the delusions of reference

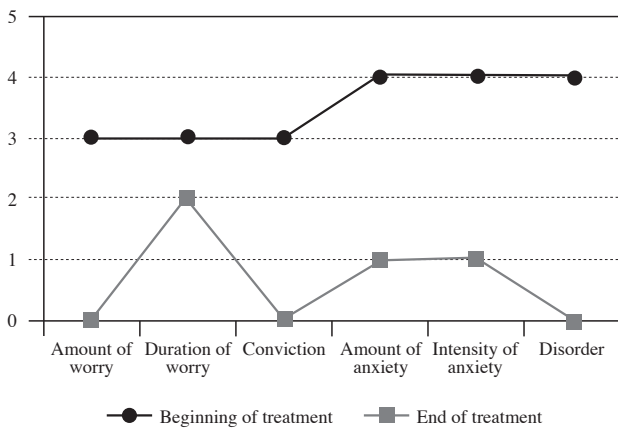


Figure 4. PSYRATS: Evolution of the delusional idea of control

Areas of recovery	Vignettes
Delusional ideas	"Now, I understand things better, and I've started to think about the smells and the unpleasant feelings in a different way. On Monday, for example, I woke up with a headache and feeling unwell, but now I didn't think it was because of the chip or because they wanted to control me. I just had a headache and felt queasy because I had an upset stomach, not because anyone wanted to harm me".
Feeling of security	"I feel strong and secure; the feelings that made me anxious have gone away, and it's, like, a massive load off my mind, that was stopping me from thinking clearly. Now I can read properly again". / "Now when I have certain feelings I tell myself it's just another experience in my mind, that nothing's going to happen".
Body image and self-esteem	"I've started to see my body in a different way; I see myself as feminine again. Before, I saw myself as masculine, ugly, distorted. Now I like my appearance, I've started wearing make-up and skirts again; I'm happy".
Autonomy	"Before, when I went shopping for clothes I always took my sister with me so that she could decide what I should buy. This year I went shopping alone to buy clothes and a handbag, and every time I go to the wardrobe and see them I feel good, because I bought them on my own".
Social functioning	"I was really unsociable, and it's not that I'm super open now, but I'm much more sociable. I don't find it so hard now to be with people; I even say hello to neighbours who I don't know from Adam".
Freedom	"The best thing of all is that I'm no longer thinking about myself all day long, about what I say or do. I feel more relaxed now; I'm not doing my own head in so much, and things turn out better. The best thing that's happening is the feeling of freedom I have now".

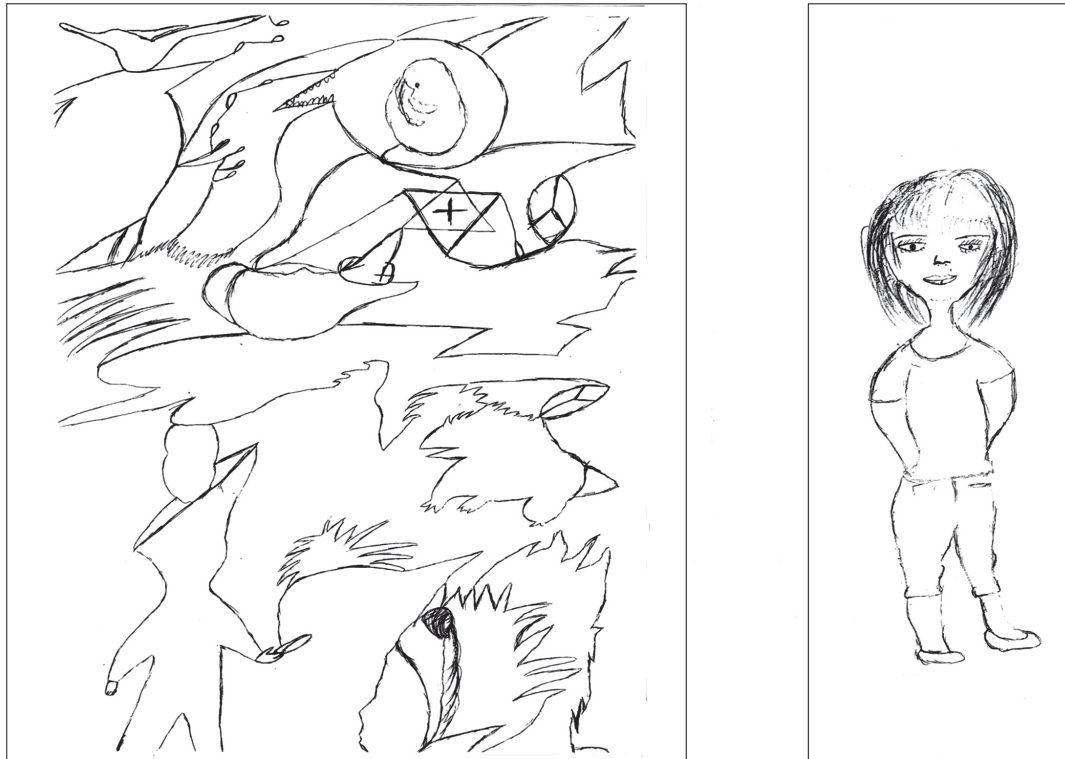


Figure 5. Self-portraits from beginning and end of the treatment

“madness” take on meaning in the biographical context, in relation to life adversities, including traumatic experiences. Otherwise, the case would simply consist in a “bunch of symptoms”, without meaning, to be fought against by means of medication.

Although there can be no certainty that the “symptoms” derive from life experience, there is a growing body of literature that helps us understand the role of depersonalization and a dissociation between traumatic experiences and psychotic symptoms, as well as the loop that maintains the person absorbed in their own experiences (Perona et al., 2013). The understandability of the symptoms for the patients themselves and their therapeutic utility endorse this biographical explanation.

A further feature of the case reported here is that the application of the therapy brought into play in an optimum fashion those components that are understood to be important in therapy for psychosis, such as engagement, a general and specific therapeutic structure and principles, a comprehensive formulation of the case, continual evaluation of the patient and adjustment to her progress, homework tasks as a bridge between the therapy and the real world, strategies for change such as validation, consideration of alternative perspectives and experimentation, and, also of great importance, assumptions by the therapist about the meaning of the symptoms and recovery from psychosis (Morrison & Barratt, 2010).

This case also presents an example of punishment paranoia, clearly distinguished in the relevant literature from persecution paranoia (Chadwick et al., 2005; Melo & Bentall, 2013). This distinction is crucial in the treatment context, and in the case reported here, PBCT appears to represent a sound psychological treatment for punishment paranoia.

PBCT represents a new approach within traditional cognitive therapy, in its development toward a more focused therapy in phenomenological and contextual terms (Skodlar, Henriksen, Sass, Nelson, & Parnas, 2013). A phenomenological-contextual notion of the self permits us to understand the “centre of gravity” of the schizophrenic disorder as an alteration of the experience of oneself and the world, and to anchor the therapy in the recovery of one’s sense of self (Nelson & Sass, 2009; Pérez-Álvarez, 2012; Sass & Parnas, 2003).

The present work is not without its limitations. Given that PBCT is a therapy based on components, the question arises as to what extent its eventual efficacy depends on specific components (and which ones), or rather, on common factors. Even bearing in mind that the specific components *work*, forming part of a whole therapeutic context (beginning with the therapeutic engagement and formulation of the case) (Pain, Chadwick, & Abba, 2008), the changes observed appear to be contingent upon the aspects worked on and successive improvements. The theoretical and practical coherence of PBCT allows us to argue that the patient’s improvement is a result of the therapy applied.

On the other hand, the patient was taking medication throughout the period of the therapy, so that we cannot rule out its possible role in the final improvement, though it should be stressed that she had been taking the medication long before the psychological therapy began, without any sign of the kind of improvements now observed. Moreover, the improvement occurred contingent upon the successive interventions and achievements, so that it is reasonable to maintain that the results are due at least largely to the therapy applied.

Possible neurobiological aspects are not considered in the therapy applied, or in the formulation of the case. They are

primarily considered as mediators and correlates dependent upon life adversities, and probably reversible in health conditions, including those achieved through psychological therapy, in line with a socio-developmental model (González-Pardo & Pérez-Álvarez, 2013; Pérez-Álvarez, 2012).

The emphasis we have placed on qualitative measures of the results, through the use of vignettes is important. Essential aspects can only be “captured” via qualitative measures, taken from the narrative of the patients themselves. There is growing interest in qualitative analysis (Stanghellini & Ballerini, 2008). Thus, the

present case-study would have the “merit” of emphasizing the patient’s first-person perspective, in coherence, moreover, with the questionnaires applied.

Follow-up was for one year, with a well distributed programme of sessions. Although longer follow-ups are always welcome, one year’s sustained improvement is clinically significant, especially given this patient’s history of progressive worsening of her condition. By the end of the therapy and during the follow-up, the patient certainly appeared to be more oriented toward social reintegration and personal recovery than to deterioration and “abandonment”.

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